Medicare Supplemental Coverage:

Weighing the Consequences and Trade-Offs for Medicare Spending and Beneficiaries

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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Vice President and Director
Medicare Policy Project
Kaiser Family Foundation

FRIDAY, DECEMBER 9, 2011
11:45AM–12:15PM—Lunch
12:15PM–2:00PM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(*Across from the Dirksen Senate Office Building*)

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OVERVIEW

As policymakers look for savings from the Medicare program, one option that has been proposed is reducing "first-dollar coverage" for Medicare services offered through privately purchased Medigap policies and other sources of supplemental coverage, such as some employer-based retiree benefits. First dollar coverage is an insurance benefit that covers all of the cost sharing, such as deductibles or coinsurance, for the use of services. The rationale for proposals to restrict first-dollar coverage comes from the theory that when an individual must pay some amount to obtain health care services, he or she will use less of that service than if the service can be accessed at no cost. These proposals are also grounded in evidence from studies that have found that Medicare beneficiaries with first-dollar coverage use more Medicare services and incur higher costs than those without first-dollar coverage. Reducing first-dollar coverage would, however, create a risk that some individuals may forgo necessary services exacerbating their health care needs. This session will examine the two most common forms of supplemental coverage for fee-for-service Medicare beneficiaries: employer-based retiree benefits and Medigap insurance. Speakers will address the benefits they provide, evidence of their effect on service use and spending, proposals to reduce first-dollar coverage, concerns about the effects of those proposals, and related policies, such as altering Medicare's benefit design and payment changes to encourage providers to deliver care more efficiently.

MEDICARE BENEFITS AND TYPES OF SUPPLEMENTAL COVERAGE

Medicare's cost sharing for services covered under Parts A and B (Table 1, next page) and the lack of an upper limit on beneficiaries' out-of-pocket spending leave beneficiaries at risk for significant out-of-pocket spending if they use a lot of health care services. For example, Medicare Part A has a relatively high deductible ($1,156 in 2012) for inpatient stays for each spell of illness and varying daily copayments for extended hospital or skilled nursing facility stays. Part B has a relatively low annual deductible ($140 in 2012), but has 20 percent copayment on physician visits and most other Part B services. Medicare's benefits and cost sharing have not changed much since 1965, with the notable exception of the addition of Part D drug benefits, beginning

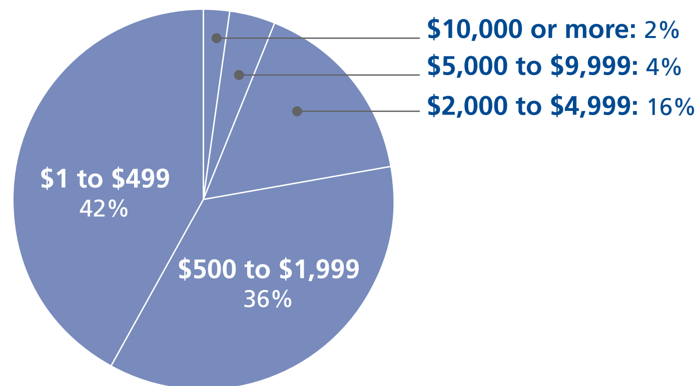
TABLE 1: Medicare Cost Sharing, 2012

SERVICES	BENEFICIARY LIABILITY
Part A	
Hospital Inpatient Stay	• $1,156 deductible per benefit period • $0 for the first 60 days of each benefit period • $289 per day for days 61–90 of each benefit period • $578 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over a lifetime)
Skilled Nursing Facility	• $0 for the first 20 days each benefit period • $144.50 per day for days 21–100 each benefit period • All costs for each day after day 100 in a benefit period
Home Health Care	• $0 for home health care services • 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	• $0 for hospice care • A copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management • 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest) • Medicare doesn't cover room and board when for hospice care in the home or another facility where a beneficiary lives (like a nursing home)
Blood	In most cases, the hospital gets blood from a blood bank at no charge. If the hospital has to buy blood, beneficiaries must either pay the hospital costs for the first 3 units of blood in a calendar year or have the blood donated.
Part B	
Part B Premium	$99.90 (beneficiaries pay more if their incomes in 2010 were over $85,000 for singles or $170,000 for couples)
Part B Deductible	$140 per year
Medical and Other Services (including physician services)	20% of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment.
Outpatient Hospital Services	Coinsurance (for doctor services) or a copayment amount for most outpatient hospital services that varies by service to phase down to 20% over time. The copayment for a single service can't be more than the amount of the inpatient hospital deductible.
Mental Health Services	40% of the Medicare-approved amount for most outpatient mental health care
Home Health Services	$0 for Medicare-approved services. Beneficiaries pay 20% of the Medicare-approved amount for durable medical equipment.
Clinical Laboratory Services	$0 for Medicare-approved services
Blood	In most cases, the provider gets blood from a blood bank at no charge. Beneficiaries pay a copayment for the blood processing and handling services for every unit of blood and the Part B deductible applies. If the provider has to buy blood, the beneficiary must either pay the provider costs for the first 3 units of blood in a calendar year or have the blood donated. Beneficiaries pay a copayment for additional units of blood received as an outpatient (after the first 3), and the Part B deductible applies.

Source: Medicare.gov, "2012 Medicare Costs," U.S. Department of Health and Human Services, available at www.medicare.gov/cost/.

in 2006 and more recently, coverage of more preventive care and the elimination of cost sharing for additional Medicare-covered preventive services. See Figure 1 for the distribution of fee-for-service (FFS) beneficiaries' Medicare cost-sharing liabilities in 2008.

FIGURE 1
Cost-Sharing Liability for Medicare Fee-for-Service Beneficiaries, 2008



Note: The amounts reflect Medicare beneficiaries' liability but do not reflect what Medicare beneficiaries actually paid out of pocket because most beneficiaries have supplemental coverage that covers all or some of their Medicare cost sharing.

Source: Medicare Payment Advisory Commission, Report to the Congress: Aligning Incentives in Medicare, June 2010, p. 54, available at www.medpac.gov/chapters/Jun10_Ch02.pdf.

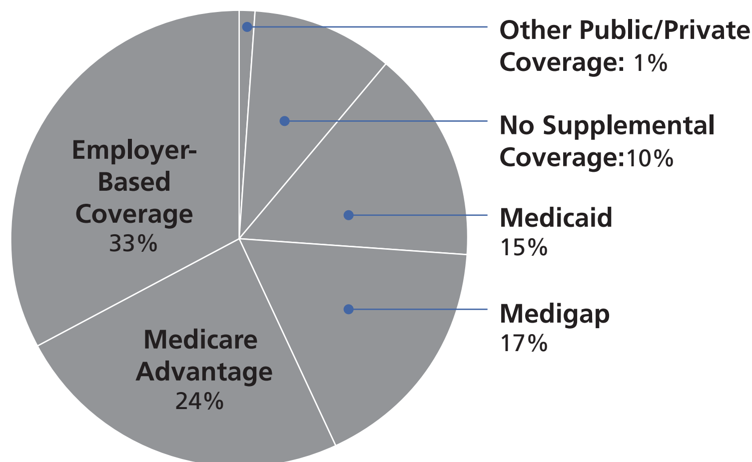
To protect against some or all of their liability for cost sharing and the absence of a cap on out-of-pocket expenditures in Medicare, 90 percent of beneficiaries have some kind of supplemental coverage (Figure 2, next page). About one-quarter of Medicare beneficiaries are in a Medicare Advantage plan, which may have lower cost sharing and offer more benefits than traditional FFS Medicare. Half of all Medicare beneficiaries have supplemental coverage through an employer-sponsored retiree plan or a Medigap policy. Fifteen percent are dually eligible for Medicaid and Medicare, and 1 percent have some other type of coverage.

EMPLOYER-BASED RETIREE COVERAGE AND MEDIGAP

As shown below, about half of all Medicare beneficiaries have employer-based retiree or Medigap coverage to supplement their

FFS Medicare benefits. These two common sources of private coverage for FFS Medicare beneficiaries are the focus of this Forum session.

FIGURE 2
Sources of Medicare Beneficiaries' Supplemental Coverage, 2008



Notes: Beneficiaries were assigned to one source of supplemental coverage in the following order: Medicare Advantage, Medicaid, employer-based, Medigap, other public/private, no supplemental coverage. Beneficiaries with more than one source of supplemental coverage were assigned to the source highest in the above-listed ordering.

Source: Mark Merlis, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," for the Henry J. Kaiser Family Foundation Program on Medicare Policy, July 2011, p. 1, available at www.kff.org/medicare/upload/8208.pdf.

Employer-Based Retiree Coverage

Employer-based coverage is the most common form of supplemental coverage for current Medicare beneficiaries, but its prevalence has been steadily declining since at least the early 1990s. To have access to employer-based retiree coverage, a Medicare beneficiary must have worked for an employer that offers such coverage and meet the eligibility requirements for the benefit.[1] As the Employee Benefits Research Institute (EBRI) noted in a recent report, at the same time the number of employers offering retiree coverage has declined, "employers have generally made it more difficult for retirees to qualify for health benefits in retirement, so not all of those who work for an employer that offers the benefit will qualify to receive it."[2] In addition, some employers have increased retirees' costs of participating in retiree health benefits just as they have increased the cost of health benefits for active employees. As a result of these trends, fewer and fewer beneficiaries will have employer-based retiree coverage available to them and will likely seek alternative forms of supplemental coverage.

The breadth of employer-based retiree coverage varies, as does the amount that the beneficiary pays to maintain the coverage and the share that is borne by the employer. A recent paper published by the Kaiser Family Foundation reported that, for Medicare-eligible retirees with employer-provided retiree benefits, employers' plans have different ways of determining the amount of Medicare cost sharing they will pay.[3] According to that paper, some employer-based retiree plans pay Medicare cost sharing in full, while others will only pay the difference between what Medicare pays and what the plan would have paid if Medicare was not the primary payer. The paper notes that "there do not appear to be any reliable data on how many employers use which method" but that benefits consultants advised that it is more common for plans to pay the difference, if any, between the plan amount and the Medicare amount.[4] Depending on a plan's cost-sharing requirements, an employer-based plan may pay nothing and require the enrollee to pay the Medicare cost sharing until an out-of-pocket limit established by the plan is reached. The Medicare Payment Advisory Commission (MedPAC) reported that, based on Medicare data from 2005, an estimated 50 percent of FFS Medicare beneficiaries with employer-based coverage paid out of pocket for 5 percent or less of their Part B spending.[5]

Employers commonly impose caps or ceilings on their total contribution to premiums for retiree health benefits. One common approach is for employers to limit their subsidy once employer spending reaches either a per-person or global cap for all retiree subsidy spending. According to EBRI, in 2009 just "one-quarter of employers who offered a retiree health benefit continued to provide a plan with no cap on its contributions for either early retirees or Medicare-eligible retirees."[6] As a result of the dwindling availability of such coverage, beneficiaries with retiree coverage will likely bear a growing share of their health care expenditures over time.

Medigap

A Medigap or Medicare supplemental policy is a private individual health insurance product that is designed to pay for costs that Medicare does not cover. By statute, Medigap policies are standardized; each plan, designated by the letters A through N, must offer the standard set of benefits regardless of the company that sells the product.[7] (See Table 2, next page, for a list of standard policies and their benefits.) In Massachusetts, Minnesota, Wisconsin, a grandfathering provision results in different standard policies being available in those three states.[8] All of the plan types cover all of the Part

A hospital deductible and hospital costs and all or some of Part B coinsurance. Plan F, which offers the most comprehensive coverage of all the plans, is the most popular plan type by far, with 44 percent of policyholders choosing it in 2010. Plan C, which offers identical benefits to plan F except for coverage for Part B excess charges,[9] is the second most popular plan with 15 percent of policyholders in 2010.[10] Plans K and L, which cover some but not all of Medicare's cost-sharing requirements and have out-of-pocket limits on beneficiary spending, are newer products that were established in the Medicare Prescription Drug, Modernization, and Improvement Act of 2003. Premiums for these two plans are generally lower than other plans but, as of 2008, they had not proven to be very popular options,

TABLE 2
Available Medicare Supplemental (Medigap) Insurance Plans

BENEFITS	A	B	C	D	F*	G	K	L	M	N
Medicare Part A Coinsurance and Hospital Costs (up to an additional 365 days after Medicare benefits are used)	●	●	●	●	●	●	●	●	●	●
Medicare Part B Coinsurance or Copayment	●	●	●	●	●	●	50%	75%	●	●**
Blood (first 3 pints)	●	●	●	●	●	●	50%	75%		
Part A Hospice Care Coinsurance or Copayment	●	●	●	●	●	●	50%	75%	●	●
Skilled Nursing Facility Care Coinsurance			●	●	●	●	50%	75%	●	●
Medicare Part A Deductible		●	●	●	●	●	50%	75%	50%	●
Medicare Part B Deductible			●		●					
Medicare Part B Excess Charges					●	●				
Foreign Travel Emergency (up to plan limits)			●	●	●	●			●	●
Out-of-Pocket Limit							$4,640	$2,320		

● *Indicates coverage of described benefit at 100 percent.*

* *Plan F also offers a high-deductible plan. If a beneficiary chooses this option, she must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,000 in 2011 before the Medigap policy pays anything.*

** *Plan N pays 100 percent of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.*

Source: Center for Medicare & Medicaid Services, Medicare & You 2012, p. 67, available at www.medicare.gov/publications/pubs/pdf/10050.pdf.

chosen by less than 0.5 percent of Medigap policyholders.[11] Plans M and N are even newer—first offered in June 2010—and they too cover some but not all of Medicare's cost sharing. Plan N is novel in that it will cover Medicare's Part B coinsurance, except for a beneficiary copayment of up to $20 for office visits and $50 for emergency department visits.

Unlike employer-based retiree coverage, all Medicare beneficiaries have access to a Medigap policy when they turn 65, provided they can pay the premiums. For 6 months after the first day of the month in which they are 65 and enrolled in Medicare Parts A and B, Medicare beneficiaries have an open enrollment period during which they are guaranteed to be issued a Medigap policy. During this open enrollment period, insurance companies cannot apply medical underwriting, refuse to sell a Medigap policy, make a beneficiary wait for coverage to start, or charge more for a policy based on health status.[12] Beneficiaries may still be able to buy Medigap after the open enrollment period, but an insurance company does not have to sell the policy if an applicant does not meet medical underwriting requirements.[13]

Beneficiaries pay a monthly premium, set by the insurance companies selling the plans, to maintain their Medigap policies. Medigap plans are priced one of three ways, depending on the insurers' policies and the laws of the state in which the plans are sold. The difference among the pricing methods for Medigap plans is the extent to which premiums vary by the age of the policyholder. Premiums for "community rated" policies are the same for everyone regardless of age. Premiums for "issue-age rated" policies are based on the age of the policyholder at the time the policy is purchased; people who initially purchase the policy when they are younger will have lower premiums over the life of the policy than those who initially purchase the policy at an older age. Premiums for "attained-age rated" policies are based on the current age of the policyholder, so the cost goes up as the policyholder ages. In 2010, the average national premium for the most popular plan F was about $172 per month, but premiums can vary widely across states and even for the same plans within different markets.[14] For example, the average monthly premium for plan F ranged from a low of $79 per month in Vermont to $220 per month in New York.[15] Plans K and L, which have not proven to be very popular with beneficiaries, have lower national average premiums: $82 per month and $122 per month respectively.[16] By law, Medigap plans are required to spend 65 cents out of every premium dollar that enrollees pay on medical care (this share is

also known as the medical loss ratio), as opposed to administrative costs, for policies sold in the individual market and 75 cents out of every premium dollar for policies sold in the group market.

PROPOSALS TO LIMIT FIRST-DOLLAR COVERAGE

Recently, and at various times since the 1990s, proposals to limit first-dollar coverage have been discussed as policymakers look for ways to cut Medicare spending (Table 3, next page).[17] As MedPAC notes in its June 2010 chapter on improving FFS Medicare's benefit design, "cost sharing is one of the few means by which the Medicare program can provide incentives to affect beneficiaries' behavior. But more than 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tools for influencing beneficiary incentives."[18]

Research on the effects of cost sharing on service use and health care spending has found that "most (but not all) Medicare beneficiaries with Medigap use more Medicare-covered services and incur higher Medicare costs than beneficiaries without supplemental coverage."[19] For example, a study for MedPAC in 2009 using data from 2003–2005 found that "secondary insurance has a substantial impact on Medicare spending, consistent with the prior literature in this area….Individuals with Medigap coverage had Medicare costs 33 percent higher than those with no secondary insurance. Other private secondary insurance was associated with smaller increases in spending."[20] The study also found that first-dollar coverage, regardless of the type of supplemental insurance, was associated with higher spending, and that types of services most affected by the presence of private supplemental insurance included elective admissions, preventive services, minor procedures, and endoscopies. The conclusion from this and similar studies, reflected in the savings estimates of current proposals to limit first-dollar coverage, is that limiting such coverage will result in use of fewer services by beneficiaries and, thus, lower Medicare spending.

The policy implications of studies finding more use among those with first-dollar coverage may be less than clear, as noted in the MedPAC study and echoed by critics of limiting first-dollar coverage. Many studies of greater service use among those with coverage cannot determine whether additional use is due to having more coverage or due to a selection effect, whereby those who need more services are more likely to buy insurance coverage.[21] Similarly, studies cannot distinguish between differences in beneficiaries' use of

TABLE 3
Restricting First-Dollar Coverage in Medicare Supplemental Policies: Recent Proposals, Options, and Estimated Savings

SOURCE	PROPOSAL	SAVINGS ESTIMATE (over 10 years)
National Commission on Fiscal Responsibility and Reform (a.k.a. Simpson-Bowles)	Prohibit Medigap plans from covering the first $500 of cost sharing and limit coverage to 50% of the next $5,000. Recommends similar provisions apply to TRICARE for Life, federal retirees, and private employer covered retirees. Replace existing cost-sharing rules with universal deductible, single coinsurance rate, and catastrophic cap for Medicare Part A and Part B.	$38 billion
Congressional Budget Office (Options for modifying cost sharing and/or prohibiting first dollar coverage)	**Option 1** • Combined annual deductible of $550 covering all Part A and Part B services • Uniform coinsurance rate of 20% for amounts above that deductible (including inpatient expenses) • Annual cap of $5,500 on each enrollee's total cost-sharing liabilities	$32 billion
	Option 2 • Prohibit Medigap policies from paying any of the first $550 of an enrollee's cost-sharing liabilities • Limit Medigap coverage to 50% of the next $4,950 in Medicare cost sharing. • Further cost sharing would be covered by the Medigap policy for beneficiaries with such policies. As a result, they would not pay more than about $3,025 in cost sharing per year.	$53 billion
	Option 3 (Combines Options 1 & 2) • Medigap plans would be prohibited from covering the new $550 combined Part A and Part B deductible • Medigap policy's cap on beneficiary out-of-pocket costs would be equal to the Medicare program's cap. • Medigap policyholders would face a uniform coinsurance rate of 10% for all services for spending between the deductible and the cap on the out-of-pocket expenditures. • Medicare beneficiaries without other types of supplemental coverage would face a uniform coinsurance rate of 20% for all services.	$93 billion
The President's Plan for Economic Growth and Deficit Reduction	Impose 30% Part B premium surcharge on new enrollees who purchase first dollar Medigap policies, beginning in 2017. Would not apply to current beneficiaries.	$2.5 billion

Source: National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 2010, available at www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf; *Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011, available at* www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf; *Office of Management and Budget, "Living Within Our Means: The President's Plan for Economic Growth and Deficit Reduction," September 2011, available at* www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

necessary and unnecessary care, nor can they definitively measure the effects of the use of additional services on health. A recent study conducted for AHIP (the association America's Health Insurance Plans) argues that while prohibiting first-dollar Medigap coverage might achieve aggregate savings, there may be a partial offset of savings related to exacerbation of conditions due to foregone services.[22] These and additional concerns about limiting first-dollar coverage, such as the stronger effect on beneficiaries with more serious health problems, are discussed more in the next section.

EFFECTS ON BENEFICIARIES OF LIMITING FIRST-DOLLAR COVERAGE: OBJECTIONS AND EVIDENCE

In addition to the recent proposals to modify first-dollar coverage shown in Table 3, Section 3210 of the Patient Protection and Affordable Care Act of 2010 (PPACA) charged the Secretary of Health and Human Services with requesting the National Association of Insurance Commissioners (NAIC) to review and revise the benefit packages of plans C and F, the most popular Medigap plans.[23] The law states that the packages are to be updated to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under Part B and that the NAIC, in its considerations, is to look at evidence published in peer-reviewed journals or current examples used by integrated delivery systems. To the extent practicable, the revised benefit packages are to be implemented as of January 1, 2015.

The NAIC Medigap PPACA Subgroup of the Senior Issues Task Force[24] charged with looking at this issue consists of state regulators, consumer advocates, and insurance industry representatives, and has not yet made its final recommendation on adding nominal cost sharing in plans C and F. However, it did issue a discussion paper[25] and a letter to the co-chairs of Joint Select Committee on Deficit Reduction[26] (a.k.a. the Supercommittee) addressing proposals to reduce first-dollar coverage in Medigap policies. The NAIC Subgroup's discussion paper, as of October 20, 2011, does not include final conclusions or recommendations, but it discusses the lack of agreement in the literature on the effect of limiting first-dollar coverage on spending and health and enumerates several objections to and concerns about proposals prohibiting Medigap insurance products from providing first-dollar coverage.[27] Among their objections, they assert that policies to restrict first-dollar coverage are based on a faulty assumption that beneficiaries drive overutilization and

overlook the role of providers in controlling the amount of services that beneficiaries receive. They also argue that such policies do not adequately consider the serious impact on beneficiaries' health that could arise from avoiding necessary services, or the disproportionate impact that such policies would have on certain groups, such as those with low or modest incomes and those who are very sick and need regular care for chronic conditions.

Another recent study undertook the task of estimating the potential effects of eliminating first- dollar coverage on Medicare spending and beneficiaries. The study, prepared for the Kaiser Family Foundation Program on Medicare Policy, used data to model the effects of three different Medigap reform proposals on beneficiaries' services use, insurers' costs for Medicare-covered services, and Medigap premiums, assuming no additional changes to the Medicare benefit design. The three options modeled are shown in Table 4.

TABLE 4
Medigap Reform Options Modeled in Analysis

OPTION	AMOUNT ENROLLEE PAYS	AMOUNT MEDIGAP PAYS	ESTIMATED MEDICARE SAVINGS, FY 2011
1: Based on CBO and similar to Simpson Bowles	First $550 of any required cost sharing for services covered under Parts A or B; 50% of additional required cost sharing up to $3,025 limit on out-of-pocket spending	50% of required cost sharing after the first $550 paid by enrollee up to $3,025 out-of-pocket spending limit; 100% of costs for Part A/B cost sharing above out-of-pocket limit	$4.6 billion
2: Similar to Medigap Plan L (more generous than option 1)	25% of Part A deductible ($1,132 in 2011); 100% of Part B deductible ($162 in 2011); 25% of required cost sharing for Part A/B services up to $2,070 limit on out-of-pocket spending	75% of Part A deductible; 75% of A/B coinsurance up to $2,070 out-of-pocket spending limit; 100% of costs for cost sharing above out-ofpocket spending limit	$2.3 billion
3: Similar to Medigap Plan N	100% of Part B deductible; $20 per office visit; $50 per emergency room visit	100% of Part A deductible and cost sharing for all other Medicare-covered services	$1.5 billion

Source: Mark Merlis, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," for the Henry J. Kaiser Family Foundation Program on Medicare Policy, July 2011, pp. i–ii, available at www.kff.org/medicare/upload/8208.pdf.

The analysis found that under the three options modeled, 78 to 83 percent of Medigap enrollees would see a reduction in net out-of-pocket costs, inclusive of Medigap premiums, which are estimated to be reduced as a result of declining Medigap insurer claim costs.[28] That is, premium reductions offset would increase out-of-pocket liability for these beneficiaries, according to these models. However, although the effects varied slightly in each of the three options tested, the analysis found that about one in five Medigap enrollees would pay more in increased cost sharing that would not be offset by premium reductions. Moreover, "reforms would have a disproportionately negative impact on enrollees with modest incomes, in relatively poor health, and those with any inpatient hospital utilization."[29] The report concludes that restricting first-dollar coverage could yield some savings for the Medicare programs and for some beneficiaries due to reduced use of services, but also cautions, as have others, that "there is no way of ensuring that enrollees who might reduce their utilization would forego only services of questionable value" and notes that more research is needed on how such policies would affect beneficiaries' health.[30]

SESSION

This session will explore (i) the effects of employer-based and Medigap supplemental coverage on Medicare spending and beneficiaries and (ii) the consequences and tradeoffs of policies for beneficiaries and the program to limit first-dollar coverage. George Wagoner, FSA, MAAA senior partner at Mercer, will discuss current retiree coverage benefit design, including cost sharing and models of Medicare integration, trends in coverage and design for future retirees, and the factors driving employer decision making. Christopher Hogan, PhD, with Direct Research, LLC, will discuss his research for the Medicare Payment Advisory Commission (MedPAC) on the evidence of the effects of supplemental coverage on service use and Medicare spending. Tricia Neuman, ScD, vice president and director with the Medicare Policy Project at the Henry J. Kaiser Family Foundation will discuss potential effects of limiting first-dollar coverage in Medigap on Medicare beneficiaries and spending, including potential changes in Medigap premiums and out-of-pocket costs for different groups of beneficiaries. She will also discuss policy considerations related to restricting first-dollar coverage, such as the potential for beneficiaries to defer necessary services and equity concerns regarding the treatment of employer-provided retiree benefits.

KEY QUESTIONS

- How should employer-sponsored benefits be considered in discussions about supplemental coverage reform? What are the difficulties of regulating employer-based supplemental coverage?
- Are beneficiaries who buy Medigap policies getting good value for their premium dollar? How much are beneficiaries willing to pay for predictability of the monthly Medigap premium versus the unpredictability of Medicare cost sharing?
- To what extent should policies to restrict first-dollar coverage be accompanied by restructuring Medicare cost-sharing requirements? How would a catastrophic limit on out-of-pocket spending reduce the need for supplemental coverage?
- How does current Medicare cost sharing and the presence of first-dollar coverage affect the program's ability to help beneficiaries distinguish high-value services, through policies like value-based purchasing?

ENDNOTES

1. Trends in the offering of retiree coverage generally reflect the behavior of large firms: "As the data show, large establishments are much more likely to offer retiree health benefits than small establishments. In 2008, 36 percent of establishments with 1,000 or more workers offered retiree health benefits to early retirees, compared with 1 percent among establishments with fewer than 10 workers. For the most part, small businesses never offered health insurance as a benefit to retirees." See Paul Fronstin, "Implications of Health Reform for Retiree Health Benefits," Employee Benefits Research Institute, Issue Brief No. 338, January 2010, p. 4, available at www.ebri.org/pdf/briefspdf/EBRI_IB_01-2010_No338_Ret-Hlth.pdf.
2. Fronstin, "Implications of Health Reform for Retiree Health Benefits," p. 4
3. Mark Merlis, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," for the Henry J. Kaiser Family Foundation Program on Medicare Policy, July 2011, p. 13, available at www.kff.org/medicare/upload/8208.pdf.
4. Merlis, "Medigap Reforms," p. 13.
5. Medicare Payment Advisory Commission (MedPAC), "Improving traditional Medicare's benefit design," chap. 2 of *Report to the Congress: Aligning Incentives in Medicare*, June 2010, p. 59, available at www.medpac.gov/chapters/Jun10_Ch02.pdf.
6. Fronstin, "Implications of Health Reform for Retiree Health Benefits," p. 7.
7. Not all types of plans may be available in all states. Insurers that sell Medigap plans must sell plan A and must also offer plan C or F if they offer additional plans. Plans E, H, I, and J are no longer sold, but those who had them before they were eliminated can keep them.

8. For the basic benefits in Massachusetts, Minnnesota, and Wisconsin, see Centers for Medicare & Medicaid Services (CMS), “2011 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,” pp. 41–44, available at www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

9. Excess charges are the difference between the amount that a physician or other provider is legally permitted to charge for a service and the Medicare-approved amount. The majority of physicians participate in Medicare, accept the Medicare allowed amount as payment, and do not “balance bill” beneficiaries.

10. Gretchen Jacobson et al., “Medigap Reform: Setting the Context,” Kaiser Family Foundation, Issue Brief, September 28, 2011, p. 3, available at www.kff.org/medicare/8235.cfm.

11. MedPAC, “Improving traditional Medicare’s benefit design,” p. 58.

12. CMS, “2011 Choosing a Medigap Policy,” p. 14.

13. There are some exceptions to this. See CMS, “2011 Choosing a Medigap Policy,” pp. 22–23.

14. Jacobson *et al*., “Medigap Reform: Setting the Context,” p. 4.

15. Jacobson *et al*., “Medigap Reform: Setting the Context,” p. 4.

16. Jacobson *et al*., “Medigap Reform: Setting the Context,” p. 4.

17. Amanda Cassidy, “Health Affairs Policy Brief: Putting Limits on ‘Medigap,’” *Health Affairs*, updated September 21, 2011, p. 3, available at www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_52.pdf.

18. MedPAC, “Improving traditional Medicare’s benefit design,” p. 50.

19. Jacobson *et al*., “Medigap Reform: Setting the Context,” p. 1.

20. Christopher Hogan, “Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly,” Direct Research, LLC, for the Medicare Payment Advisory Commission, June 2009, p. 2, available at www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf.

21. For additional discussion of this issue and discussion of the literature, see MedPAC, “Improving traditional Medicare’s benefit design,” pp. 50–55.

22. Cory Capps and David Dranove, “Intended and Unintended Consequences of a Prohibition on Medigap First-dollar Benefits,” for America’s Health Insurance Plans, October 2011, p. 2. Another recent study also observed that an increase in cost sharing for physician services and prescription drugs in an employer-based plan for retirees resulted in significant increases in hospital spending for beneficiaries with chronic conditions. See A. Chandra, J. Gruber, and R. McKnight, “Patient Cost Sharing and Hospitalization Offsets in the Elderly,” *American Economic Review*, 100, no. 1, March 2010. For a brief summary of several studies, including Chandra *et al*., on the effect of patient cost sharing on health care spending and health outcomes, see also Sarah Goodell and Katherine Swartz, “Cost-sharing: Effects on spending and outcomes,” Robert Wood Johnson Foundation, Synthesis Project Policy Brief No. 20, December 2010, available at www.rwjf.org/files/research/121710.policysynthesis.costsharing.brief.pdf.

23. "Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010]," available at http://docs.house.gov/energycommerce/ppacacon.pdf.

24. "National Association of Insurance Commissioners (NAIC), "NAIC Medigap PPACA Subgroup–Participant List," updated May 24, 2011, available at http://naic.org/documents/committees_b_senior_issues_medigap_ppaca_sg_membership.pdf.

25. NAIC and The Center for Insurance Policy and Research, letter to Senator Murray and Representative Hensarling, September 21, 2011, available at www.naic.org/documents/committees_ex_grlc_110921_letter_murray_hensarling_medigap_first_dollar.pdf.

26. NAIC Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost-Shares," Discussion Paper, October 20, 2011, available at http://naic.org/documents/committees_b_senior_issues_medigap_ppaca_111025_discussion_paper.pdf.

27. NAIC, "Medicare Supplement Insurance First Dollar Coverage and Cost-Shares."

28. These results are dependent on a number of assumptions discussed in the paper. See the "Methodology" section of Merlis, "Medigap Reforms," beginning on page 5, for a complete description of the study's methods.

29. Merlis, "Medigap Reforms," p. iv.

30. Merlis, "Medigap Reforms," p. 14.